Medical Affidavit

I, _____, being first duly sworn, depose and say as follows:

1. I am a physician employed by the _____.
   My specialty is _____.

2. I received my degree from _____ in _____. After completion of a residency in _____ at _____, I became employed at/began to consult for _____.

3. _____is a _____ year-old _____ whom I examined on _____ for the purpose of_____ _____.

4. _____'s present condition is/diagnoses are as follows: _____ _____ _____.

5. It is my opinion that because of his/her mental condition as evidenced above, _____ is unable to receive and evaluate information effectively, or his/her ability to communicate decisions is impaired to such an extent that he/she lacks the capacity to take actions to:

   ☐ obtain, administer and dispose of real and personal property, intangible property, benefits and income AND/OR

   ☐ provide health care, food, shelter, clothing, personal hygiene and other care without serious physical injury or illness is more likely than not to occur AND/OR

   ☐ acquire and maintain those life skills that enable him/her to cope more effectively with the demands of his/her life.

5. Based on the information above, I affirm that _____ is unable to make decisions and provide consent for medical treatment.

_____
Physician's Signature

Physician's Name (printed):_____

Street Address:_____

_____

Phone number/Pager number: _____

Subscribed and sworn this _____day of _____ 20__.

_____
Notary Public

My commission expires: